



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

COLUMBIA RIO GRANDE REGIONAL
HOSPITAL
C/O DAVIS FULLER JACKSON KEENE
11044 RESEARCH BLVD STE A-425
AUSTIN TX 78759

Respondent Name

ZURICH AMERICAN INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-98-A673-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The provider submitted the billing for the same and received a payment from Risk Management, the carrier, in the amount of \$2,970.00." "As to the per diem rates adopted by the carrier said rates contained in the guidelines for inpatient acute care have been held to be void and unenforceable by the Supreme Court of Texas." "In light of the above, the provider asserts it is owed the full amount of the bill, which is fair and reasonable. At the least the carrier owes 80% of the total charges pursuant to the 'old law'."

Amount in Dispute: \$15,081.31

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

Response Submitted by: None

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
November 24, 1997 through November 27, 1997	Inpatient Hospital Services	\$15,081.31	\$384.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 *TexReg* 6264, sets out the reimbursement guidelines for inpatient hospital services.
3. This request for medical fee dispute resolution was received by the Division on March 6, 1998.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - M-Reduced to fair and reasonable.
 - Please note a 15% reduction according to the assigned facility fee ratio.
 - The carrier has adopted the per-diem as fair & reasonable.
 - C-Negotiated amount.

Findings

1. The respondent reduced payment of the disputed services with reason code “C-Negotiated amount”. No documentation was found to support a contractual agreement between the parties to this dispute. This denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
2. This dispute relates to inpatient medical services provided in a hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.401.
3. 28 Texas Administrative Code §134.401(b)(1)(B), states “Inpatient Services – Health care, as defined by the Texas Labor Code §401.011(10), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute care hospital.”

A review of the submitted medical bill and itemized statement, indicate that the requestor billed for three (3) inpatient surgical day; therefore, this admission meets the definition of inpatient services per 28 Texas Administrative Code §134.401(b)(1)(B).

4. 28 Texas Administrative Code §134.401(c)(1) states “Standard Per Diem Amount. The workers’ compensation standard per diem amounts to be used in calculating the reimbursement for acute care inpatient services are as follows: Surgical \$1,118.”
5. 28 Texas Administrative Code §134.401(c)(3)(B), the reimbursement calculation formula is “LOS X SPDA = WCRA.” Therefore, 3 days multiplied by \$1,118.00 = \$3,354.00.

A review of the submitted explanation of benefits supports reimbursement of \$2970.00 was made for the inpatient surgical services. The difference between the per diem rate of \$3,354.00 and amount paid of \$2,970.00 is \$384.00.

The requestor supported position that additional reimbursement of \$384.00 is due for inpatient services.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports additional reimbursement of \$384.00 is due the requestor. As a result, the amount ordered is \$384.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$384.00 plus applicable accrued interest per 28 Texas Administrative Code §134.803 due within 30 days of receipt of this Order

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	12/22/2011 Date
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YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.